wcb Workers' Compensation Board – Alberta

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993

C533
PHYSICAL THERAPY SERVICES FIRST REPORT

WORKER DETAILS

Surname	First Name and Initial		Gender ☐ Male ☐ Female	WCB Claim Number
Address Street	City/Town	Province Postal Code		Date of Birth *(yyyy/mm/dd)*
				Telephone Number

Worker's Job Title/Occupation:	Progressive Injury? ☐ Yes ☐ No	Date of Injury *(yyyy/mm/dd)*
Describe how and when the injury/condition occurred.		Date of Exam *(yyyy/mm/dd)*

Examination
Symptoms:

Objective Findings:

Diagnosis:

ICD Code 1:	ICD Code 2:	ICD Code 3:

Part of body:	Side of Body:	Nature of Injury:

Are you aware of any prior conditions in the same anatomical area? ☐ Yes ☐ No If yes, describe

Affected Movements Patterns

Type	ROM left (degrees)	ROM right (degrees)	Strength

Pain Scale:	Type of Pain:

Reflex Normal? ☐ Yes ☐ No If no, describe

Sensation Normal? ☐ Yes ☐ No If no, describe

Myotomes Normal? ☐ Yes ☐ No If no, describe

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Surname	*First Name*	WCB Claim Number:

Any other findings
(Including functional status)?

Treatment Plan

Any complicating factors affecting recovery? ☐ Yes ☐ No If yes, describe:

Surgery? ☐ Yes ☐ No If yes, Actual or estimated date of surgery *(yyyy/mm/dd)*

Consultation(s)/Referral(s)/Investigation(s) ☐ Contact with WCB Case Manager ☐ Contact with PT Consultant ☐ Referral to Return to Work Provider

Treatment complete? ☐ Yes ☐ No If yes, discharge recommendations:

Has the worker missed work beyond the date of accident? ☐ Yes ☐ No

Has the patient returned to work? ☐ Yes ☐ No If yes, date returned *(yyyy/mm/dd)*

If returned to work, what is the worker's current work status? ☐ Full duties and hours ☐ Modified Hours _____ ☐ Modified duties

If patient is currently not working or is working modified duties, complete the following.
Please make a selection below as they relate to the injury:

Sitting	☐ Able	☐ Unable	☐ Limited to ____ Hours
Standing	☐ Able	☐ Unable	☐ Limited to ____ Hours
Walking	☐ Able	☐ Unable	☐ Limited to ____ Hours
Bending	☐ Able	☐ Unable	☐ Limited
Twisting	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting	☐ Able	☐ Unable	☐ Limited

Climbing	☐ Able	☐ Unable	☐ Limited
Lifting	☐ Able	☐ Unable	☐ Limited, Max of _____ (lbs/kg)
Pushing / pulling	☐ Able	☐ Unable	☐ Limited
Overhead reaching	☐ Able	☐ Unable	☐ Limited
Driving	☐ Able	☐ Unable	☐ Limited to ____ Hours

Other reasons why the patient cannot work:
☐ Hospitalized ☐ Self reported pain ☐ Opioids/Medication side effects

Other restrictions or additional comments/special considerations:

☐ Estimated Return to Work to pre-accident work date *(yyyy/mm/dd)* or ☐ permanent restrictions anticipated

Name and address to whom fee is payable: (please print)	Signature	Printed Name
	Telephone Number	Fax Number
WCB Billing Number: _____	Provider's Reference Number	Date *(yyyy/mm/dd)*